

ILLINOIS STANDARD HEALTH APPLICATION FOR INDIVIDUAL & FAMILY HEALTH INSURANCE COVERAGE		
PRIMARY APPLICANT NAME	DAT	E
DEPENDENT NAME (If submitted s	separately)	
F Additional Information - Separate Sheet		
If you answered "YES" to any of the questions in Section E, you must provide additional information below.		
Question Number:	Name of Individual:	
Condition/Diagnosis:		
Treatment Received:		
Treatment anguing TVac	7 No. First 9 Last Treatment Date.	
Treatment ongoing? Yes No First & Last Treatment Date:		
		_ Currently taking medication? ☐ Yes ☐ No
Question Number:	Name of Individual:	
Condition/Diagnosis:		
Treatment Received:		
Treatment ongoing? Yes No First & Last Treatment Date:		
Additional tests or treatment recommended?		
Medication Prescribed (if any):		
Physician Namo		_ Currently taking medication? ☐ Yes ☐ No
	City & State	
Question Number:		
_		
rreatment Received:		
Treatment ongoing? Yes No First & Last Treatment Date:		
Additional tests or treatment r	ecommended?	
Medication Prescribed (if any):		
		_ Currently taking medication? ☐ Yes ☐ No
Phone # ()	City & State	

Signature: _____ Date: _____